		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019364

Facility Name: Central Nursing

Address: 2450 North Central Avenue (Number) Chicago (City) 60639 (Zip Code)

County: Cook

Telephone Number: (773) 889-1333 **Fax #** (773) 889-1516

IDPA ID Number: 362801271001

Date of Initial License for Current Owners: 01/01/1973

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Sanford B Alper - Principal
(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C.
1101 Lake Cook Road Suite C Deerfield, IL 60015-5233
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 245

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	76,319	3,344	6,401	86,064	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	76,319	3,344	6,401	86,064	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.44%

D. How many bed-hold days during this year were paid by Public Aid?
843 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 2,380

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,380	60,473	13,386	270,239		270,239	0	270,239			1
2	Food Purchase		180,224		180,224	(26,280)	153,944	0	153,944			2
3	Housekeeping	157,564	10,478	3,780	171,822		171,822	0	171,822			3
4	Laundry		8,546		8,546		8,546	0	8,546			4
5	Heat and Other Utilities			119,758	119,758		119,758	0	119,758			5
6	Maintenance	40,410		49,705	90,115		90,115	89	90,204			6
7	Other (specify):*				0		0	0	0			7
8	TOTAL General Services	394,354	259,721	186,629	840,704	(26,280)	814,424	89	814,513			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	1,583,246	56,726	2,964	1,642,936		1,642,936	0	1,642,936			10
10a	Therapy	28,450		12,717	41,167		41,167	0	41,167			10a
11	Activities	50,933		1,093	52,026		52,026	0	52,026			11
12	Social Services	14,909		4,474	19,383		19,383	0	19,383			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):* Physician Care			510	510		510	0	510			15
16	TOTAL Health Care and Programs	1,677,538	56,726	21,758	1,756,022	0	1,756,022	0	1,756,022			16
	C. General Administration											
17	Administrative	210,620		22,983	233,603		233,603	0	233,603			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			36,487	36,487		36,487	142	36,629			19
20	Dues, Fees, Subscriptions & Promotions			28,316	28,316		28,316	(4,050)	24,266			20
21	Clerical & General Office Expenses	206,089	12,504	7,439	226,032		226,032	4,010	230,042			21
22	Employee Benefits & Payroll Taxes			324,492	324,492	26,280	350,772	18,407	369,179			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			2,183	2,183		2,183	0	2,183			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			188,847	188,847		188,847	0	188,847			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	416,709	12,504	610,747	1,039,960	26,280	1,066,240	18,509	1,084,749			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,488,601	328,951	819,134	3,636,686	0	3,636,686	18,598	3,655,284			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Central Nursing #0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			51,585	51,585		51,585	67,006	118,591			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes			208,621	208,621		208,621	0	208,621			33
34	Rent-Facility & Grounds			1,207,200	1,207,200		1,207,200	(1,207,200)	0			34
35	Rent-Equipment & Vehicles			16,195	16,195		16,195	0	16,195			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,483,601	1,483,601	0	1,483,601	(1,140,194)	343,407			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			75,561	75,561		75,561	0	75,561			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			134,137	134,137		134,137	0	134,137			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	209,698	209,698	0	209,698	0	209,698			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,488,601	328,951	2,512,433	5,329,985	0	5,329,985	(1,121,596)	4,208,389			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,367	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(25)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule	(4,060)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 4,982		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,126,578)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,126,578)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,121,596)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Central Nursing

ID# 0019364

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax - Mng Allocation	$ (10)	21	1
2	Non Deductible Dues	(4,050)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,060)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	89	0	0	0	0	0	0	0	0	0	89	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	89	0	0	0	0	0	0	0	0	0	89	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	142	0	0	0	0	0	0	0	0	0	142	19
20	Fees, Subscriptions & Promotions	(4,050)	0	0	0	0	0	0	0	0	0	0	(4,050)	20
21	Clerical & General Office Expenses	(335)	4,345	0	0	0	0	0	0	0	0	0	4,010	21
22	Employee Benefits & Payroll Taxes	0	18,407	0	0	0	0	0	0	0	0	0	18,407	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,385)	22,894	0	0	0	0	0	0	0	0	0	18,509	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,385)	22,983	0	0	0	0	0	0	0	0	0	18,598	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,367	57,639	0	0	0	0	0	0	0	0	0	67,006	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,207,200)	0	0	0	0	0	0	0	0	0	(1,207,200)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,367	(1,149,561)	0	0	0	0	0	0	0	0	0	(1,140,194)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,982	(1,126,578)	0	0	0	0	0	0	0	0	0	(1,121,596)	45

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram	Chicago	Nursing Home
Joseph Mermelstein	50.00%	Emerald Park Nursing Center	Evergreen Park	Management, Inc.		Management
		Balmoral Home	Chicago			
		Sovereign Healthcare, LLC	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$	Nivram Management, Inc.	50.00%	$ 168	$ 168	1
2	V	21	Office Expense		Nivram Management, Inc.	50.00%	168	168	2
3	V	21	Supplies		Nivram Management, Inc.	50.00%	3,317	3,317	3
4	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	10	10	4
5	V	19	Accounting		Nivram Management, Inc.	50.00%	142	142	5
6	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	16,999	16,999	6
7	V	21	Telephone		Nivram Management, Inc.	50.00%	657	657	7
8	V	22	Group Insurance		Nivram Management, Inc.	50.00%	1,408	1,408	8
9	V	6	Repairs & Maint.		Nivram Management, Inc.	50.00%	89	89	9
10	V	21	St Replacement Tax		Nivram Management, Inc.	50.00%	25	25	10
11	V	34	Rent	1,207,200	Henry Mermelstein	0.00%		(1,207,200)	11
12	V	30	Depreciation		Henry Mermelstein	0.00%	57,639	57,639	12
13	V								13
14	Total			$ 1,207,200			$ 80,622	$ * (1,126,578)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	None	100,000	48	60.00	Salary	$ 150,000	L 17, Col 1	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	52,000	40	42.22	Salary	38,000	L 1, Col 1	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	85,442	4	20.89	Salary	22,558	L6 Col 1	3
4	Doreen Mermelstein	Office Manager	Administrative	None	89,112	5	13.95	Salary	14,448	L 21, Col1	4
5	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	128,164	6	20.89	Salary	33,836	L 17, Col 1	5
6	Joseph Mermelstein	Owner	Administrative	50.00%	68,216	3	28.19	Salary	26,784	L 17, Col 1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 285,626		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc,
Street Address: 2155 West Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: ((773) 252-3208
Fax Number: ((773) 252-368

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	1,173	6	$ 805	$	245	$ 168	1
2	21	Office Expenses	Resident Beds	1,173	6	805		245	168	2
3	21	Supplies	Resident Beds	1,173	6	15,880		245	3,317	3
4	21	Franchise Tax	Resident Beds	1,173	6	50		245	10	4
5	19	Accounting	Resident Beds	1,173	6	682		245	142	5
6	22	Payroll Taxes	Resident Beds	1,173	6	81,386		245	16,999	6
7	21	Telephone	Resident Beds	1,173	6	3,145		245	657	7
8	22	Group Insurance	Resident Beds	1,173	6	6,740		245	1,408	8
9	6	Repairs & Maint.	Resident Beds	1,173	6	424		245	89	9
10	21	St Income Tax	Resident Beds	1,173	6	115		245	25	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 110,032	$		$ 22,983	25

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	204,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	203,521	2
3. Under or (over) accrual (line 2 minus line 1).	$	(979)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	209,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	208,621	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	214,990	8
	1998	218,807	9
	1999	217,338	10
	2000	198,472	11
	2001	203,521	12

2001 Tax bill = 203,521. Estimated increase 1.03% = 209,627.
Rounded = $209,600

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019364

CONTACT PERSON REGARDING THIS REPORT Sanford Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-29-431-013-0000	2450 N. Central Avenue	$ 11,624.61	$ 11,624.61
2.	13-29-431-014-0000	2450 N. Central Avenue	$ 27,777.43	$ 27,777.43
3.	13-29-431-015-0000	2450 N. Central Avenue	$ 27,819.19	$ 27,819.19
4.	13-29-431-016-0000	2450 N. Central Avenue	$ 27,819.19	$ 27,819.19
5.	13-29-431-017-0000	2450 N. Central Avenue	$ 27,786.12	$ 27,786.12
6.	13-29-431-018-0000	2450 N. Central Avenue	$ 27,720.58	$ 27,720.58
7.	13-29-431-019-0000	2450 N. Central Avenue	$ 27,625.51	$ 27,625.51
8.	13-29-431-020-0000	2450 N. Central Avenue	$ 22,101.42	$ 22,101.42
9.	13-29-431-021-0000	2450 N. central Avenue	$ 1,576.78	$ 1,576.78
10.	13-29-431-022-0000	2450 N. Central Avenue	$ 1,670.09	$ 1,670.09
		TOTALS	$ 203,520.92	$ 203,520.92

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	30,000	1973	$ 158,977	1
2					2
3	TOTALS	30,000		$ 158,977	3

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1973	1973	$ 1,729,156	$	30	$ 57,639	$ 57,639	$ 1,695,114	4
5					(95,563)						5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1976	8,246		20			8,246	9
10	Hot Water Heater			1983	2,156		10			2,156	10
11	Light Fixtures			1984	14,684		10			14,684	11
12	Roof			1984	20,000	498	20	1,000	1,000	18,417	12
13	Heating & Air Conditioning			1983	2,924		20	146	146	2,725	13
14	Painting & Decorating			1983	7,863		8			7,863	14
15	Doorways			1986	1,840	97	15			1,840	15
16	Elevator Upgrade			1986	1,080	57	20	54	54	849	16
17	Wall Corner Guard			1987	1,531	49	10			1,531	17
18	Resurface Parking Lot			1987	6,900	219	15	317	317	6,900	18
19	Additions			1988	1,200	38	20	60	60	828	19
20	Heater Foundation			1989	1,000	32	20	50	50	640	20
21	Roof			1990	7,916	251	20	396	396	4,837	21
22	Roof			1990	2,199	70	8			2,199	22
23	Various Improvements			1990	1,850		8			1,850	23
24	Cubicle Curtains			1992	11,273	358	10	681	681	11,273	24
25	HVAC Improvements			1993	8,907		10	892	892	8,622	25
26	Draperies			1993	2,700		10	270	270	2,610	26
27	Tiling			1995	6,600	169	10	660	660	5,060	27
28	Leasehold Improvements			1995	15,914		10	1,591	1,591	12,198	28
29	Generator			1996	17,527	449	10	1,753	1,753	11,686	29
30	Roof			1996	4,800	123	10	480	480	3,200	30
31	Door			1997	2,465	63	10	247	247	1,399	31
32	Wiring for Emergency System			1997	5,000	128	10	500	500	2,833	32
33	Phone System			1997	8,238		10	823	823	4,664	33
34	Architecture			1998	6,000	154	10	600	600	2,800	34
35	Boiler, A/C, Ductwork			1998	16,664	427	10	1,666	1,666	7,775	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roofing	1998	$ 54,000	$ 1,385	10	$ 5,400	$ 4,015	$ 25,200	37
38	Parking Lot Improvements	1998	8,000		10	800	800	2,933	38
39	Elevator Improvements	1998	4,450	68	10	445	377	1,632	39
40	HVAC Improvements	1998	2,820	72	10	282	210	1,034	40
41	Fire Alarm System & Doors	1999	107,500	2,756	10	10,750	7,994	39,417	41
42	Extended Walls Through Ceiling	1999	3,000	77	10	300	223	1,100	42
43	Elevator Improvements	1999	2,650	68	10	266	198	975	43
44	HVAC Improvements	1999	20,388	523	10	2,038	1,515	7,473	44
45	Landscape Work	1999	4,100	105	10	410	305	1,503	45
46	Elevator Improvements	2000	89,750	2,301	10	8,975	6,674	23,934	46
47	HVAC Improvements	2000	23,639	606	10	2,364	1,758	6,304	47
48	Telephone System	2000	7,500	192	10	750	558	2,000	48
49	Air Conditioning System	2001	4,000	64	10	400	336	800	49
50	Air Conditioning System	2001	10,800	277	10	765	488	1,530	50
51	Air Conditioning System	2001	2,500	38	10	125	87	250	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,166,167	$ 11,714		$ 103,895	$ 95,363	$ 1,960,884	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 78,545	$ 10,739	$ 7,855	$ (2,884)		$ 55,280	71
72	Current Year Purchases	25,717	24,558	1,286	(23,272)	10	1,286	72
73	Fully Depreciated Assets	351,675			0		351,675	73
74					0			74
75	TOTALS	$ 455,937	$ 35,297	$ 9,141	$ (26,156)		$ 408,241	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Storage	Storage Trailer	1986	$ 900	$	$	$ 0	4	$ 900	76
77	Administrative	1999 Oldsmobile	1999	22,218	4,574	5,555	981	4	11,110	77
78							0			78
79							0			79
80	TOTALS			$ 23,118	$ 4,574	$ 5,555	$ 981		$ 12,010	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,804,199	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,585	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,591	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 67,006	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,381,135	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 16,195 Description: Ice Makers $900 Copier $1,831 Mattresses $13,464
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	15-3	12 visits	510				12	510	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				45,131		45,131	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): EnteralTube Feeding	39-3					30,430		30,430	13
14	TOTAL			$ 510		$	$ 75,561	12	$ 76,071	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 260,382	$ 206,382	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,333,258	1,333,258	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,500	56,500	6
7	Other Prepaid Expenses	461,315	461,315	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,111,455	$ 2,057,455	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	446,792	505,922	15
16	Equipment, at Historical Cost	328,305	529,317	16
17	Accumulated Depreciation (book methods)	(369,522)	(2,204,931)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	500,100	500,100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 905,675	$ 1,218,541	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,017,130	$ 3,275,996	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 20,036	$ 20,036	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,082	86,082	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,840	23,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)	209,600	209,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Rent	400,924	400,924	36
37	Due to IDPA	350,495	350,495	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,090,977	$ 1,090,977	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,090,977	$ 1,090,977	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,926,153	$ 2,185,019	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,017,130	$ 3,275,996	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,424,271	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,424,271	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,131,882	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,630,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 501,882	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,926,153	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,304,530	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,304,530	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,767	6
7	Oxygen	127,552	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 133,319	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,130	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,233	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,363	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,678	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,678	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	54	28
28a	Vending	15,354	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,408	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,497,298	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	840,704	31
32	Health Care	1,756,022	32
33	General Administration	1,039,960	33
	B. Capital Expense		
34	Ownership	1,483,601	34
	C. Ancillary Expense		
35	Special Cost Centers	75,561	35
36	Provider Participation Fee	134,137	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,329,985	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,167,313	41
42	**Income Taxes**	(35,431)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,131,882	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,794	2,018	$ 67,893	$ 33.64	1
2	Assistant Director of Nursing	2,048	2,312	54,332	23.50	2
3	Registered Nurses	28,909	31,878	671,757	21.07	3
4	Licensed Practical Nurses	9,137	10,858	168,301	15.50	4
5	Nurse Aides & Orderlies	76,010	84,485	620,963	7.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,321	2,477	28,450	11.49	8
9	Activity Director	1,910	1,950	17,568	9.01	9
10	Activity Assistants	5,462	5,720	33,365	5.83	10
11	Social Service Workers	1,939	2,107	14,909	7.08	11
12	Dietician	1,174	1,377	19,275	14.00	12
13	Food Service Supervisor	2,080	2,080	38,000	18.27	13
14	Head Cook	3,123	3,363	35,997	10.70	14
15	Cook Helpers/Assistants	14,316	15,321	103,108	6.73	15
16	Dishwashers					16
17	Maintenance Workers	2,021	2,177	40,410	18.56	17
18	Housekeepers	18,282	23,343	157,564	6.75	18
19	Laundry					19
20	Administrator	2,672	2,672	176,784	66.16	20
21	Assistant Administrator	293	293	33,836	115.48	21
22	Other Administrative	312	312	50,084	160.53	22
23	Office Manager	257	257	14,448	56.22	23
24	Clerical	10,980	11,598	141,557	12.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,040	206,598	$ 2,488,601 *	$ 12.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 13,386	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,740	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	1,224	10-3	39
40	Physical Therapy Consultant	L	9,785	10A-3	40
41	Occupational Therapy Consultant	Y	1,967	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	965	10A-3	43
44	Activity Consultant	E	1,093	11-3	44
45	Social Service Consultant	E	4,474	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,634		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Henry Mermelstein	Administrator	0.00	$ 150,000
Marvin Mermelstein	Asst. Admin.	50.00	33,836
Joseph Mermelstein	Administrator	50.00	26,784
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 210,620

B. Administrative - Other

Description	Amount
Nivram Mng Inc - Management Fees	$ 22,983
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 22,983

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Orlean, Silver & Co.	Accounting	$ 12,600
Richard Peelo	Medicare Consulting	4,200
Accu-Med Services	Computer Support	2,280
Immigration & Naturalization	Registration Service	405
Personnel Planners, Inc.	U/C Consultant	1,380
System Management	Billing Consultant	6,379
Medi.com	Computer Support	528
Health Data Systems	Computer Support	5,265
Howard Reich	Legal	3,450
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 36,487

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,765
Unemployment Compensation Insurance	12,984
FICA Taxes	157,977
Employee Health Insurance	89,675
Employee Meals	26,280
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,492
Other Employee Benefits	11,599
Allocation from Management	18,407
TOTAL (agree to Schedule V, line 22, col.8)	$ 369,179

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,909
Health Care Worker Background Check (Indicate # of checks performed)	
Licenses & Permits - see Attached Sch. A	13,357
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,266

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,083
Seminar Expense	1,100
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,183

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $13,367**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,080** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **134,137**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,280** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees